



MIR NEUROLOGY & SPINE CENTER

600 Memorial Ave Suite 304
Cumberland, MD 21502
301-722-3777

11110 Medical Campus Rd, Suite 151
Hagerstown, MD 21742
301-797-7600

Date: _____ Patient Name: _____ Marital Status: S, M, D, W, Sep.

Height: _____ Weight: _____ Primary Care Doctor: _____

Referring Physician: _____

Reason for today's visit: _____

Is your condition related to a car or work injury: Y / N

Date of accident or injury _____

Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Past Surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____

Medications:

Dose:

How Often (Frequency):

- | | | |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |
| 7. _____ | _____ | _____ |

Allergies and Reactions:

1. _____
2. _____
3. _____

Social History:

Occupation: _____

Is your job? Heavy Moderate Light • Alcohol use: Never Occasionally Daily

History of heavy alcohol use? Y / N • Do you smoke? Y / N • Currently: _____ pack(s) per day _____ year(s)

Past: _____ pack(s) per day _____ year(s) • History of drug abuse or drug addictions? Y / N

Family History:	Alive	Deceased	Age	Health
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Mother: _____

Father: _____

Brother/Sister: _____

Brother/Sister: _____

Brother/Sister: _____

Please list diseases that are common in your family _____ . Over

Systems Review

Gastrointestinal:

- Indigestion or pain with eating Y N
Nausea Y N
Vomiting Y N
Jaundice Y N
Ulcer or Gastritis Y N

Musculoskeletal:

- Arm weakness/pain Y N
Leg weakness/pain Y N
Back and neck pain Y N
Joint pain or swelling Y N
Arthritis Y N

Integumentary:

- Skin disease Y N

Psychiatric:

- Anxiety Y N
Depression Y N
Other psychiatric disorder/treatment Y N
Explain: _____

Hematological/Lymphatic:

- Anemia Y N
Bleeding tendencies Y N

Respiratory:

- Cough Y N
Shortness of breath Y N
Wheezing Y N

Ear, Nose, Throat, and Mouth:

- Wear hearing aid Y N
Hearing loss Y N
Ringing in ears Y N
Balance disturbance Y N
Sinus problems Y N

Other: _____

Genitourinary:

- Urinary tract infection Y N
Loss of control of urination Y N
Kidney stones Y N
Endometriosis (female) Y N
Erectile dysfunction (male) Y N
Night urination Y N

Neurological:

- Seizures Y N
Memory problems Y N
Back Pain Y N
Neck Pain Y N
Tremors Y N
Insomnia Y N
Leg pain when walking Y N
Tingling/numbness in hands/feet Y N

Endocrine:

- Fatigue Y N
Intolerance to heat Y N
Intolerance to cold Y N
Excessive thirst Y N

Eyes:

- Wear glasses Y N
Glaucoma Y N
Cataracts Y N
Double vision Y N
Blurred vision Y N

Cardiovascular:

- Chest pain or angina Y N
Swelling in hands/feet Y N
Palpitations Y N

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ DATE: _____